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AUTHOR Hill, Brent Mathews
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ABSTRACT

A clinical peer review of client treatment at the Weber Mental Health Center, a facility serving two Utah counties, was conducted. Gathered from 25 randomly selected charts of clients 8 years of age and younger who were seen during the period 1978-1982 and whose treatment was terminated, data indicated that 28 percent of the sample was improperly in treatment, 60 percent received at least partially inappropriate treatment, and at least 8 percent participated in significantly more than the average number of therapy sessions. To remedy this situation, the practicum described in this report employed a psychodiagnostic assessment program to determine whether services were needed and, if so, to give direction to the early stages of treatment. Major components of the intervention included individual and family interaction assessment and a behaviorally oriented procedure for reporting results to the attending therapist. A total of 10 young children were evaluated during the course of the practicum. Goals of significantly reducing improper and misdirected treatment were achieved. The third objective, reducing the length of treatment, was not met. Staff evaluation of training suggests that psychology interns and mental health staff were successfully trained in the area of early childhood psychodiagnostic assessment. However, instruments found most useful for early childhood assessment are not commerically available. (Author/RH)

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DEVELOPMENT AND IMPLEMENTATION OF A PSYCHODIAGNOSTIC ASSESSMENT PROGRAM FOR YOUNG CHILDREN IN A MENTAL HEALTH CENTER

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NOVA UNIVERSITY

DEVELOPMENT AND IMPLEMENTATION OF A PSYCHODIAGNOSTIC ASSESSMENT PROGRAM FOR YOUNG CHILDREN IN A MENTAL HEALTH CENTER

PRACTICUM I SUBMITTED TO THE FACULTY OF THE
EARLY CHILDHOOD PROGRAM
IN CANDIDACY FOR THE DEGREE OF

DOCTOR OF EDUCATION

BY

BRENT MATHEWS HILL

NOVA UNIVERSITY
CLUSTER IX

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OBSERVER'S NAME: S. Craig Campbell, Ph.D.

OBSERVER'S POSITION: Staff Psychologist

OBSERVER'S BUSINESS ADDRESS: Weber Mental Health Center

2510 Washington Boulevard, Ogden, Utah 84401

ABSTRACT

Development and Implementation of a Psychodiagnositc Assessment Program for Young Children in a Mental Health Center.

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Ed.D. Early Childhood Program

Descriptors: Clinical Diagnosis/Diagnostic Tests/Early Childhood Education/ Personality Measures/Psychological Evaluation/Psychological Testing

This practicum addressed the need to decrease the number of young children whose psychological treatment was improper, misdirected, or longer than necessary due to inadequate clinical evaluation. In reviewing the literature it was found that inadequate diagnostic study was the primary cause of faulty, inappropriate treatment. A review of randomly selected charts revealed a significant number of young children had received inappropriate or misdirected treatment. A small percentage had received treatment deemed too lengthy.

The writer's goals were to decrease improper, misdirected, or too lengthy treatment attributable to inadequate assessment. To address these goals the writer implemented a psychodiagnostic assessment program specifically designed to determine if services were needed and if so, to give direction to the early stages of treatment. Major components included individual and family interaction assessment and a behaviorally-oriented procedure for reporting results to the attending therapist.

The goals of significantly reducing improper and misdirected treatment were achieved. The third objective of reducing the length of treatment was not met.

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Chapter One: Introduction

Background Information

The Weber Mental Health Center was the setting for this practicum. The Center is a community mental health center which has been in operation since 1970. The community mental health center concept was established by the Kennedy Administration, with the passage of the Community Mental Health Act. This act provided for the establishment of mental health centers and clinics nationwide. Each center serves roughly 250,000 citizens. Their primary purpose is to provide mental health services for any citizen who wishes them with a fee based on his or her ability to pay.

The Center, as required by law, provides inpatient, outpatient, and 24-hour emergency mental health services. It also provides psychiatric medication management as well as consultation and education services. Services are provided to residents within a defined catchment area. The catchment area for the Weber Mental Health Center includes all of Weber and Morgan Counties in the State of Utah.

Community Information

Weber and Morgan counties are located in north central Utah. The southeastern boundary of Weber County is contiguous with the western boundary of Morgan County. The Great Salt Lake forms the western boundary of Weber County while all of Morgan County is contained within the Wasatch Range of the Rocky Mountains. The community served by the center is 40 miles due north of Salt Lake City.

The area has all socioeconomic levels represented but is predominantly middle class. Ogden, the Weber County seat and largest city, contains a large lower class population in its central city area. This group is predominantly Black and Hispanic. The population of Weber County is approximately 128,000 with around 60,000 living in Ogden. The population of Morgan County is nearly 10,000.

The major employer in the area is the Federal Government, which lends economic stability to the area. Federal installations include Hill Air Force Base, an Internal Revenue Service center, and the Defense Depot-Ogden (D.D.O.). The Thiokol and Hercules Corporations, large federal contractors, also have plants in the area.

Writer's Role and Responsibilities

The writer, a licensed marriage and family therapist, serves as a staff psychologist and graduate practicum supervisor in the youth program component of the Weber Mental Health Center.

Inherent in this position is the provision of mental health inpatient, outpatient, and consultation services to youth from birth to eighteen years of age and their families. The writer also provides consultative, evaluative, and educative services to individuals and agencies within the catchment area and therapy supervision to graduate students in the allied helping professions.

Chapter Two: Study of the Problem

Problematic Existing Conditions

The Weber Mental Health Center started its clinical operation in 1970. Since its inception there has been high community usage of its resources, both inpatient and outpatient. The traditional means of acquiring services has been to request services, be assigned to a therapist and then make initial contact with that therapist.

The first meeting with the therapist consisted of signing several required federal, state, and local forms. In addition the therapist was required to take a comprehensive case history and formulate a treatment plan detailing first clinical impressions, the probable course of treatment, and the expectations and time frames associated with termination from active mental health services. This pattern existed in both the adult and youth components of the Center until quite recently (Eden, Note 2).

Campbell (Note 1) notes that this produced an emphasis on paperwork and excessive documentation which was further heightened when the Center sought Joint Commission on the Accreditation of Hospitals (JCAH) accreditation. He further notes that these demands did not subside after the Center dropped participation in the JCAH program. Johnson (Note 3) found that this emphasis produced poorer diagnostic study of the center's clients.

This type of approach met the needs of federal, state, and local regulating bodies for record completeness and documentation (Eden, Note 2). It did not meet the needs of the center's therapists and most important, it did not meet the needs of the clients assigned to the youth team. As Campbell (Note 1) commented, "Those kinds of constraints, coupled with high caseloads and the frequent requirements to 'overdocument' made it so that you could not do therapy."

The discrepancy between the existing and an ideal situation was clear. Treatment could not possibly be adequate when demands were focused on record dimensions and not client dimensions. Campbell (Note 1) contends that this discrepancy is even more acute in the case of the young child who needs attention focused on accurately diagnosing problems that show themselves in unique and different ways, unlike the adult who can more accurately verbalize his or her concerns.

Campbell (Note 1) has noted that some of the paperwork problems cited were addressed and remedied by this writer during the past year. This was done by computerization of some records, designing a comprehensive checklist case history form, and the introduction of a parent orientation meeting where non-clinical business can be more efficiently handled.

Despite these improvements there was still inappropriate treatment occurring due to lack of appropriate diagnostic study of the young child entering treatment. Tallent (1983, p. 11) has concluded that, "Misdiagnosed people are likely to receive faulty treatment." Area agencies had noted an improvement in recent years in the diagnostic study of the

adolescent client but not in the younger clients (Johnson, Note 3). Johnson (Note 3) further contends that the lack of well targeted treatment adversely affects not only the client but the client's family and the therapist as well, since he or she becomes frustrated.

Johnson (Note 3) and Campbell (Note 1) have concluded that several factors have influenced the nonresolution of the current problem. The problems of young children are not always as visible as those that affect adults and adolescents. Young children are seldom regarded as independent consumers and seldom protest inadequate treatment. Johnson (Note 3) also sees the lack of staff training as a major hindrance to resolving the problem. He concludes that the lack of training and experience in the use of psychodiagnostic measures is the most common barrier to adequate diagnosis and hence treatment. Campbell (Note 1) observes that most of the current staff have had little academic training in the use of such measures.

The problem was, therefore, that there were children from birth to eight years of age at the Weber Mental Health Center who were receiving treatment that was improper, misdirected, and possibly longer than necessary. This problem was directly related to the problem of inadequate diagnostic study of the child client.

Documentation of the Problem

In July of 1982 a clinical peer review of randomly selected charts of terminated clients seen from 1978-1982 was conducted. Peer review is a process whereby one or more therapists review the work of their clinical peers and evaluate it according to predetermined standards.

The charts of all clients eight and younger were extracted and every fifth one was drawn from the alphabetically arranged file. This sample was further modified by removal of those clients seen only once or referred elsewhere at intake. The remaining cases had an N of 25. Thirteen of the cases selected involved males while twelve of the cases involved females.

These twenty-five cases were then subjected to a three point clinical peer review to determine if the case was appropriate for treatment, appropriately directed as related to diagnosed problems, and to determine if treatment was longer than necessary. The form used in this review is found in Appendix A.

In regard to the number of children who were improperly in treatment it was found that 28% of the sample could be so classified. These were children who on the average had attended two to five therapy sessions before it was determined that psychotherapy was not a proper modality of treatment for them.

The second category dealt with therapy which was determined to be at least partially misdirected in relation to the helpfulness and appropriateness of the interventions to the diagnosed disorder or in the relationship of the disorder to the diagnosis. The review found that 60% of the sample fit under this category. There was some overlap between this category and the previous category.

The final area of concern dealt with the length of treatment. The average number of therapy sessions, usually an hour in length, was found to be twenty. Clinical experience of the peer reviewers tends to confirm an average or reasonable length of a course of family therapy is around twenty sessions. Eight percent of the sample exceeded this limit to a significant degree. It should be noted, however, that Weber Mental Health Center studies have found the center's average number of therapy hours per case to be twelve. This figure represents the median appointments for 1981. The use of the median as opposed to the mean takes into account the fact that the center also services an adult chronic population. The length of therapy, therefore, will be monitored to see if it is impacted under this proposal.

Analysis of the Problem

There were several probable causes to the above outlined problem. These causes included center characteristics, therapist characteristics, and client characteristics.

Center characteristics included a lack of age-appropriate instruments for the diagnostic study of young children and a bias against psychometric assessment by the center's administrative staff. The lack of instruments was in ways directly related to the administration's bias against such instruments. This bias had been diminishing over the previous three years, however. The bias, in part, stemmed from the fact that nearly all of the senior members of the staff were graduates of one graduate school of social work where there was very little training or emphasis given to formal assessment of clients. Thus when

this group established spending priorities, training in and purchase of psychodiagnostic instruments was not a high priority. This bias shifted somewhat with the inclusion of staff from several different schools and different orientations. In addition to staffing changes the staff had also become more involved with other centers, children and adolescent hospitals, and with the juvenile court system. All of these interactions paved the way for increased use of formal assessment. Nonetheless, this was a slow moving process of institutional change.

Therapist characteristics which contributed to the problem included a lack of training and experience with younger children, ready access to instruments for adolescents but not for younger children, and a routinely high caseload.

Most of the therapists on staff who had training in formal assessment were trained primarily on adult or adolescent clients. In addition, only about 30% of the population served by the youth team were eight years of age and under. This proportion of youth to adolescents perpetuated the overbalance of training and experience with the older clientele.

The final therapist characteristic which contributed to the problem was that of routinely high caseloads. The fact that each therapist had high caseloads was not a direct causal factor in the problem situation but was a factor that perpetuated its existence.

The lack of nontherapy working time precluded the therapists from becoming actively involved in program improvements such as upgrading services to young children.

Client characteristics also contributed to the problem. To more accurately understand the implications of clients causing or perpetuating this problem one has to address what these young clients were and are not now doing.

These young clients lack what might be termed political power. The severity of their problems seldom results in extreme violence to others, as an adolescent's behavior might. The very young are seldom before the juvenile court system and seldom ordered into therapy. Thus when dealing with adolescents the therapist is often dealing with a court ordered client who will require periodic reviews before the court. When dealing with the young child, who may eventually become a similarly troubled adolescent, the therapist is usually dealing with a somewhat distraught parent who has requested help with the youngster. The political and power implications are clear.

In addition to the political power that the younger population lacks, they also lack skills which could enable them to help remedy the situation. While the adolescent can give verbal feedback about therapist behavior, center policy, and his own progress or lack of it, the young child usually lacks such verbal skills and therefore cannot give corrective feedback.

In summary then, it appears that causal factors related to this problem can be found at the mental health center level, the therapist level, and in the nature and developmental characteristics of the young child client.

Relationship of the Problem to the Literature

In reviewing the literature on the assessment of children this writer found that most studies dealing with the problem of assessment of children could be classified in three general areas. The first area deals with the lack of understanding of the value of psychodiagnostic assessment. The second area is related to it and deals with past abuses in the area of assessment and current issues of civil liberty. The third problem area deals with the lack of assessing the characteristics and functioning of the family in which the young child lives. These areas will be dealt with individually.

Citing the criteria needed for psychological service delivery systems to function adequately Maher (1979) notes that they must have procedures for the identification, assessment, and treatment of clients in a technically adequate manner. Keat (1979) contends that the accurate delineation of problems is the necessary first step in an effective treatment program. Other studies (Mowder, 1980; Ho, Glanville, & Brave, 1980) have also indicated the direct linkage of assessment to subsequent programming.

Sperber (1970) emphasizes the need for assessment to be rapidly accomplished so that the client can be matched with the mode of psychotherapy, there are several, which promises to be most constructive for him. The work of Ho et al. (1980) cited earlier also relates that such assessment is not only possible but essential for special populations such as the developmentally disabled. In publishing its current Diagnostic and Statistical Manual of Mental Disorders (APA, 1980), the American Psychiatric Association greatly expanded its diagnostic categories but also cautioned practicioners that several areas of problematic development were not subsumed within its categories. Thus while emphasizing the need for diagnosis it noted special problems which may be inherent in the diagnostic study of the young child.

The literature then can be seen to indicate that there is a definitive link between assessment of clients and their subsequent treatment while at the same time noting certain obstacles to effectively completing such assessment.

The second area the literature touches on is the diagnostic abuse or misuse of assessment procedures. Some of the abuse has its origins in the early research which initially reports the assessment procedures in the research literature. O'Leary and Turkewitz (1978) have pointed out that several research reports that appear in the social science journals are very unclear on characteristics of their research subjects, therapists or examiners, experimental treatment specifications, and

possible biases or confounding variables. In addition, the authors pointed out that many samples were not representative of larger populations but were as a rule young, attractive, verbal, intelligent, and successful.

Beyond their initial presentation to the scientific community the assessment measures under discussion have also been abused and misused by practicing professionals. Rice (1973) stops short of abandoning assessment because it does have great positive value. He does, however, argue that practicioners need to use assessment in a more selective way in order to meet the specific needs of the client. Anastasi (1968) notes in her classic work on assessment that many of the concerns over testing have come about out of reactions to invasion of privacy, concerns about assessment measuring only social conformity or social class. She also points out that professionals have been naive in their claims of accuracy while interpreting such measures. These factors, along with the social and educational implications of categorization prompted an anti test revolt in the 1960's which is still producing implications in the 1980's.

The third area the literature cites is that assessment has traditionally been individually oriented. This facet of assessment would seem to make an implicit claim that problems all originate with the individual. The literature calls this assumption into question as far as young children are concerned. The family tends to emerge as a very decisive element in referral, assessment, and treatment.

In several studies (Lobitz & Johnson, 1975a; Lobitz & Johnson, 1975b; Johnson & Lobitz, 1974; Anderson, 1969; Wolking, Quast, & Lawton, 1966; Liverant, 1959) it has been found that parents of referred children are more psychologically disturbed than parents of non-referred children. Most of these studies have employed the Minnesota Multiphasic Personality Inventory (MMPI) as an assessment tool for use with parents. Parents of referred children scored significantly higher on scales which measure depression, hysteria, anxiety, hypochondriasis, and sociopathic tendencies. Jenkins (1966) was able to go beyond this seminal hypothesis and classify children's psychiatric syndromes in relation to their family background. Thus it becomes clear that assessment which does not take into account the family of the young child will prove to be less than adequate in producing clinically usable data.

Chapter Three: Anticipated Outcomes and Evaluation Instruments

Statement of General Goals

This practicum was designed to improve the psychotherapeutic treatment of young children at the Weber Mental Health Center by improving their psychological assessment prior to their entering treatment. If the practicum was successful it seemed reasonable to expect that fewer children would be involved in improper, misdirected, or longer than necessary treatment.

Terminal Behavioral Objectives

The following goals were projected for this practicum:

1. Less than 10% of the children, ages birth to eight years, in treatment at the Weber Mental Health Center will be determined, by process of clinical peer review, to be improperly in treatment.
2. Less than 20% of the children, ages birth to eight years, in treatment at the Weber Mental Health Center will be determined, by a process of clinical peer review, to be in therapy which was at least partially misdirected.
3. The mean number of hours spent in therapy will be reduced by 10% from its current level of 20 hours.

Description of Evaluation Instrument

The evaluation instrument used in this practicum is a clinical peer review survey form. (The reader is referred to Appendix A for the complete instrument.) This form consisted of several forced-choice responses to perceived inadequacies in treatment. The peer reviewer used the survey to review several cases which formed the initial sample and documented the problem.

The evaluation instrument contained identifying information and other variables that were monitored during the practicum process. These other variables included age at intake, sex, and the child's diagnosis.

Beyond the identifying information the survey contained five questions. The first question asked the reviewer to determine from diagnostic information contained in the chart if psychological treatment was appropriate for the child. The second and third questions (Numbered 2A and 2B) sought to determine if the diagnostic information at intake was representative of the course of treatment which followed. The third question was only to be answered if the reviewer could rate the diagnosis and treatment as congruent. If treatment logically follow diagnosis, the reviewer was asked to decide from information within the chart if the treatment interventions were helpful. If either the second or third question were rated in the negative direction, the treatment was seen as misdirected.

The fourth and fifth questions dealt with the length of treatment. The reviewer was asked in the fourth question to make a determination

based on information in the chart if treatment appeared too lengthy due to inadequate diagnosis. The fifth question asked the reviewer to identify how many therapy hours were consumed in the course of treatment. In this manner it was felt that the length of treatment could be viewed in both an objective as well as a subjective manner.

The reasons behind the selection of this type of an instrument were very basic. There were no commercially available instruments which would measure the areas we wished to measure. In addition, this process was similar to the process employed by monitoring agencies and Weber Mental Health staff could easily adapt to conducting such a review. Finally, this type of a survey is suitable for use as a pre-measure and as a post measure.

Chapter Four: Solution Strategy

Previously Utilized Solutions

Since Tallent (1983), Campbell (Note 1), and Johnson (Note 3) linked misdirected, faulty, and lengthy treatment with inadequate diagnosis, especially in the case of the Weber Mental Health Center, this writer surveyed previously utilized solutions for similar problems.

In selecting a solution strategy it became clear that certain characteristics of the population in question could be utilized to aid in the more appropriate implementation of any solution strategy.

Miller, Hampe, Barrett, & Noble (1971) found that although boys and girls demonstrated similar problematic behaviors, boys tended to show more of them at any given time. The authors also noted that young children will rarely show a large number of symptoms attributable to a given syndrome but will often show facets of several symptoms, thus highlighting the need for accurate diagnosis. In explaining the larger number of males referred for therapy services the authors pointed out that their study indicated that children are referred for treatment when they become problematic to adults. Boys tend to externalize while girls tend to internalize. Thus fewer girls are referred. This confirms the earlier findings of Stone, Wilson, Spence, & Gibson (1969).

Schectman (1970) noted that younger children display more symptoms or facets of symptoms than do older children. This study

also found that the dimensions of externalization-internalization were constant over time in children.

Several studies (Sines, Pauker, Sines & Owen, 1969; Lanyon, 1970; Achenbach & Edelbrock, 1978) have gone beyond identification of problems in the general population to identifying relevant dimensions for clinical applications. By using factor analysis these studies have noted that behavioral dimensions which are most often seen in diffuse symptomotogical form can be reduced to basic characteristics of aggression, anxiety, and somatization.

From these studies one can see that any solution strategy to an early childhood assessment problem must take into account age and the dimensions of externalization, aggression, anxiety, and somatization.

The literature suggested a myriad of possible solutions that have been previously utilized and bear on this type of problem. These solutions could be categorized as psychodiagnostic examinations, checklist ratings, interviewing, behavioral, family systems, social, interdisciplinary, and inpatient solutions. Each of these will be examined individually.

Psychodiagnostic examinations have been described in the literature for decades (Keat, 1974, 1979; Korchin, 1976; Anastasi, 1968; Jensen, 1965). They consist of objective and projective measures of intelligence, interest, development, aptitude, attitude, and personality. They are generally conducted individually and terminate in a report which includes

information on the subject's scores and their meaning in relation to local and/or national norms, and recommendations for follow-up.

The psychodiagnostic examination has many merits. It has been used in many different psychological and educational settings. It gives a clear picture of where an individual ranks in relation to those around him and is accepted as a standard of the trade. It's limits were addressed earlier in this paper and included the social implications of testing, cultural bias, limitations of generalization, and privacy considerations (Anastasi, 1968). It is also limited by the time element involved and by the narrowing of assessment to the individual and an intrapsychic perspective. Most of the literature on the examination relates to its use with adults or older adolescents. Schoonover (1970) found that the WISC, an intelligence test commonly employed in evaluations, fails to differentiate any of the major psychiatric syndromes. It is therefore only useful if information on intelligence is needed to aid in treatment, or backup clinical hunches.

Copel (1969) is one of the few authors who has devoted significant attention to dealing with infant and pre-school psychodiagnostic assessment. Keat (1974, 1979) has given considerable attention to the psychodiagnostic study of the elementary aged child. The New Jersey State Department of Education (1980) published a guide which can assist those in the assessment field conduct non-biased psychodiagnostic assessments. Some studies (Wetter, 1980; Miller, 1977; Mintz, 1969) have also dealt with improving the psychological report and helping parents gain

benefit from such a service.

In summary then the psychodiagnostic examination is useful across populations and settings and is well accepted in the profession. It is limited by its narrow individual perspective, several social implications, little use with the very young, and the time-cost factor.

Checklist ratings were developed, in part, due to the time element involved in the psychodiagnostic examination and in part evolved from the factor analytic studies which identified several relevant dimensions or factors in children's behavior (Achenback & Edelbrock, 1978; Baker & Dreger, 1977; Cattell & Dreger, 1974). Some checklists have also been designed to give global behavioral scores or designed to be sensitive to single traits such as stress (Chandler, 1981) or manifest anxiety (Reynolds, 1980).

Thus checklists have the advantages of being flexible in terms of content, application, and age. Checklists also possess a savings of time over the traditional psychodiagnostic assessment.

Wilson (1981) has cautioned practicioners who use rating scales that many are not technically adequate. When using checklists the clinician should ascertain reliability and validity data, see that rated behaviors are clearly defined, and be sure that the manner the responses are made in is consistent with the type of behavior being observed. Wilson also notes that the clinician needs to be aware of which assessment function he wishes to use the instrument for, i.e., description, prescription, diagnosis, prediction, or evaluation.

Checklists are currently in use in the writer's work setting. They are administered at the new client orientation and appear to meet Wilson's standards. The studies cited had similar populations to that served at the Weber Mental Health Center.

Interviewing has been used as an independent method of assessment and conjointly with other methods of assessment. Interviews vary as to the amount of formal structure they possess. Some interviews present rigid sequential material to be explored (Dinkmeyer & Dinkmeyer, 1977) while others use unstructured format so that interviewer-interviewee interactions may be observed (Sperber, 1970). Like the checklists these interview formats may produce global data (Shapiro, 1979) or may yield data in very specific areas such as depression (Kashani et al., 1981), self-esteem (Ackerman, 1980), or psychosomatic status in children (Wright, 1978).

Thus the advantages of the interview are its flexibility and applicability to several different populations and situations, its opportunity for direct observation of the client in a therapy-like setting, and its ability to be used with or without other forms of assessment.

Limitations of this model can be seen in the status of the presenting problem of this practicum. The nonstructured format of diagnostic interviewing has been the status quo at the center and has produced the results noted in the documentation section. This is not

a total indictment of the interview method but does seem to indicate that an unstructured diagnostic interview used without other types of assessment fails to adequately address the problem of improper, misdirected or longer than necessary treatment. The data in this practicum would seem to indicate that if the interview is used it should be more structured, relate to important elements as revealed by the literature, and be used conjointly with other methods of assessment.

Behavioral Approaches to assessment stress measurement of observable behavior emitted by the client. There is little or no reference to hypothetic constructs which cannot be seen, such as motivation. Behavioral approaches tend to reject formal psychodiagnostic assessment since it generally is predicated on nonobservable entities such as personality traits. Behavior assessment measures and quantifies frequency, intensity, duration, antecedents, and consequences of observable behavior.

Advantages of behavioral approaches are that they are at once diagnostic, prescriptive, and evaluative of progress. If a child is emitting thumb-sucking behaviors you diagnose him as a thumb sucker, as opposed to being insecure, you reinforce behavior incompatible with thumb sucking and refrain from reinforcing thumb sucking as a prescriptive measure, and evaluate progress by counting the frequency or duration of present thumb sucking. Kazdin (1979) has outlined several varieties of behavioral treatments which have proven effective in treatment of a large number of presenting complaints. Tracy (1977)

has shown that phrasing the results of an intake screening in behavioral terms for the receiving therapist has a significant effect on lessening client attrition. Consumer satisfaction has also been shown to be quite high when assessment and treatment are targeted on observable behaviors (O'Leary, Turkewitz, & Taffel, 1973).

The limitations of the behavioral approaches are that they tend to ignore facets of personality, family, and social functioning which many therapists feel contribute to or sustain deviant behavior in children. A prime example of this assertion would be the previously cited literature which addressed the high incidence of psychopathology in the parents of referred children. The behavioral approach would only quantify and intervene in the presenting complaint, the child's deviance. Many child therapists tend to believe that acting out behaviorally is the way a child deals with an underlying feeling that he lacks the skill or understanding to articulate. This facet of child functioning is also ignored by the behavioral model.

The behavioral model then, is a very therapeutically economical model that is completely self-contained. Its major drawbacks are that it tends to ignore affective, cognitive, familial, and social aspects of child functioning. This model is partially adhered to by the youth program staff but no one on staff identifies him or herself as exclusively behavioral in orientation or training.

Family systems approaches to diagnosis and treatment are those approaches which take into account that perhaps the most important ecosystem humans are situated in is the family (Framo, 1979). Family approaches emphasize that members of the family apart from the identified patient can be helps in diagnosing problems and act as agents of change toward the patient (Simpson & Poplin, 1981; Levant & Haffey, 1980; Chetik, 1977). Family approaches may utilize many forms of assessment within the context of the family. Structured interviews may occur (Granger & Wanberg, 1967), checklists may be given (Locke & Wallace, 1959), or the family may be asked to complete certain objective or projective measures jointly or severally. The family orientation also holds that problems must be viewed in a larger context than just the individual. Indeed, some problems may be a manifestation of a problem occurring elsewhere in the family or in the family as a whole. This information can only be examined in the context of family interaction. Studies (Pinsof, 1981; Schuham, 1972; Murrell & Stachowaik, 1967) have demonstrated that factors such as rigidity, talking time, and spontaneous agreement can be used to diagnose problem areas or disturbed families. These facets of behavior can only be monitored in the context of family diagnosis and treatment.

Limitations of the family systems model include a lack of specificity, often, about the client's problematic behaviors. Haley (1963, 1970, 1976, 1979) is a notable exception since he addresses himself

to the family's exact presenting problem. This is still done within the context of the family however. Other limitations attributed to the family systems approach is that it ignores larger systems which also affect individual and family functioning such as the school and the community.

Social approaches flow logically from the basic premises of the family approach. Those who advocate the social approach point out that the family approach is aimed in the right direction but fails to take into account the impact of the larger social community and its significant institutions such as the schools, the churches, or peer groups. Judah and Keat (1977) have devised a classroom ecology schedule which allows the observer to assess the classroom system and how it can impact the individual client. Morraco (1977) suggests that observation of students occur in the natural setting of the classroom and take into account all of the occurrences and interactions. The social approach is flexible in its application to various populations and situations. Its limitation parallel those of the family model. The family model of assessment is sometimes considered too far removed from the individual to impact his specific problem. This is borne out by the instruments employed by practicioners of the social approach, many lack specificity or individual diagnostic value. Social assessment instruments are also difficult to locate in the literature or from psychological instrument suppliers.

Interdisciplinary approaches stress that several different helping professionals should be involved in the individual's case (Blai, 1981; Carberry, 1975). It is felt that many perspectives on a single problem provide a more comprehensive and inclusive assessment and also provide for an improved treatment plan. The most significant area of the interdisciplinary approach in relation to the current practicum problem is an interdisciplinary approach involving cooperation between mental health centers and the schools (Barr & Delfava, 1980; Greer, 1976; Carberry, 1975). These studies indicate that tremendous potential to assess and impact childhood problems is available when the school with its educational expertise and the mental health center with its psychological expertise form a collaborative team. This area is just now being pioneered in American pre-schools as the attention of professionals shifts to treating younger children. Herjanic (1972) has noted that schools are one of the major referral sources for mental health centers, so such collaboration serves in everyone's best interests.

Some authors (Lindeman & Saunders, 1967) have suggested that regardless of how the assessment is performed, its interpretation should be done by a multidisciplinary team to the parents. This has the effect of producing significantly greater acceptance of recommendations given.

The greatest limitations of the interdisciplinary approach are its cost in time and money. When two or more therapists spend an hour with one family that means that the additional therapy hours that could have been provided by the additional therapists are not available.

Lindeman and Saunders (1967) counter with the assertion that such an approach is cost-effective since it tends to eliminate resistance on the part of the clients, thus shortening treatment.

Assessment by teamwork also has the drawback resulting in compromise or consensus diagnoses that are acceptable to all and objectionable to none. Many of the studies reviewed for this paper involved interdisciplinary team diagnoses. They tended to employ ten to fifteen common diagnoses that were regularly and consistently applied to their clientele. Thus the factors which have the potential to produce the greatest benefit from this model also have potential to limit its usefulness. That is to say that a group with varied backgrounds can contribute to greater understanding of the client but it can also be limited by social pressures from the group process itself.

Inpatient or residential approaches form the final class of previously utilized solutions to this type of problem. In essence the residential model is one where the client resides in a therapeutic community composed of other patients, trained professionals, and usually a multidisciplinary team of physicians, psychologists, social workers, nurses, and sometimes educational personnel.

The therapeutic community provides a milieu that is conducive to total manipulation of all variables that could be affecting the client. This is one of its greatest benefits. It can therefore utilize elements from nearly all of the previous approaches

(Lowenstien, 1980; Richer & Gantcheff, 1977). At present the residential approach to diagnoses alone, without subsequent residential treatment, is limited to penal systems and state hospitals and has not been used extensively otherwise. Programs that provide inpatient therapy concurrent with or subsequent to inpatient diagnoses have found several models quite workable (O'Keefe & Castaldo, 1981; Wax, 1971). Wax uses a therapeutic day program model in his work with preschoolers. O'Keefe and Castaldo have employed a multimodal method of assessment and subsequent treatment in a child care agency.

Despite the advantages of this model with its ability to utilize several of the other models already discussed, it has several serious drawbacks.

It is accepted clinical practice to only employ residential solutions when all other solutions have been exhausted or when the severity of the problem is such that it poses a threat to the well-being of the client or others around him. Inpatient solutions are also quite expensive. Hospital rooms for psychiatric admissions in the Ogden area range from $150.00 to $200.00 per day.

There are also serious therapeutic limitations with inpatient solutions. It is not uncommon to assess and treat a child in a residential program, see him improve, discharge him, return him home, and see a serious deterioration in his past progress. This may be due to

factors such as a lack of adequate structure, inadequate parent training, or the psychopathology of the parents themselves as noted earlier in this paper.

Thus, although the residential model has the highest probability of utilizing the beneficial facets of the other models of assessment, it is the least feasible in terms of cost, time, and ethical considerations.

Description and Justification for Selected Solutions

The description of the above models serves to illustrate that there are many solutions that have been utilized in similar settings with varying degrees of success. To attempt to apply all of these solutions to the current problem would result in an extremely lengthy and possibly counterproductive assessment ordeal. Economic, political, and philosophical considerations of the Center rule out several facets of the previously utilized solutions. This writer therefore chose several applicable elements from these varied solutions that seemed appropriate to overcome the identified causes of the current problem, have the greatest possibility of meeting the terminal objectives previously outlined, and result in improved psychotherapeutic treatment of young children.

The selected strategy consisted of eight components:

1. Acquisition by the writer for the Center of several of the basic psychodiagnostic instruments identified during this writer's review of the literature (See Appendix B) and their selective administration to new clients below nine years of age.

2. Modified use of the structured projective interview suggested by Copel (1969). (See Appendix C).
3. Retention of the use of checklists in the present new client orientation. These are also included in Appendix B.
4. Assessment of family systems functioning by structured observation, prescribed family tasks, and objective measures. (See Appendix B).
5. Case-by-case utilization of mental health-school/agency collaboration.
6. Utilization of Tracy's (1977) model in formatting the assessment report in behavioral terms for the therapist. (See Appendix D).
7. Training, by the writer, of others on the staff in the administration of selected early childhood instruments. Training was to be open to all staff and was to be evaluated by the recipients. (See Appendix E).
8. Dissemination of practicum results to the youth program staff and administration to provide a tested solution for improvement of psychological treatment, and a rationale for further cost-effective diagnostic study.

The components of the solution strategy will be discussed in detail.

The first and eighth components addressed the probable causes of the problem that were attributed to center characteristics, namely the lack of appropriate psychodiagnostic instruments and a diminishing but nonetheless present bias against such instruments.

The therapist characteristics which were noted as probable contributing causes included a lack of experience and training in the use of assessment techniques with young children, a small percentage of the clinical population (30%) being under the age of eight, and high caseloads. This practicum addressed the training and experience causes with its seventh component but did not directly address the other two areas.

The solution strategy also took into account that the client characteristics which prevent attention being given to solving this problem include a lack of political power within the center, socially less severe problems, and an inability of young clients to articulate usable feedback on services. The fact that this practicum attended to this age group gave them greater visibility and clinical attention. The evaluation of the practicum results provided a method of feedback on the effectiveness of such services.

Thus the reader can see that in its design this strategy sought to remedy several of the identified causal factors. By further describing each of the solutions components it is hoped that the reader will become aware of how this strategy also addressed the concerns identified earlier in the literature.

The first component consisted of assessment device acquisition. Several of the studies cited earlier contained specific recommendation for the assessment of children and are included in Appendix B. These devices were acquired through purchase, loan, or reproduction of the noncopyrighted instruments. The literature is clear that such devices

should be used to address specific referral questions and not as a lock-step method. Intelligence measures were not routinely employed but used only when this was called for, per Schoonover's (1970) work cited earlier.

The second component consisted of using an abbreviated and modified version of Copel's (1969) interview format which employs directed projective questioning. Past use of the unstructured interview had poor results and additional structure provided partial improvement in the problem situation. The interview format is found in Appendix C.

The third component provided for retention of a portion of the center's existing program which appeared justified by the literature and by in-house program evaluation. This component was the selective use of behavioral checklists and questionnaires. This phase of the practicum was already in place in the new client orientation meeting designed by the writer. These instruments are noted in Appendix B.

The fourth component of the solution strategy was the expansion of assessment to include the family system. This was accomplished by use of structured observational formats, objective and projective family measures, and through the use of structured family tasks. This component addressed the concerns found in the literature about the psychopathology of parents of referred children as well as total family pathology. These measures are cited in the family section of Appendix B.

The fifth component represented a case-by-case attempt to involve schools and other agencies in the assessment and treatment planning of young children. It was felt that employment of the social approach along with the aforementioned family approach would then involve the major

institutions that impact upon the child. This included special efforts when the child is in preschool to both train and gain information from the area preschool staffs. It was hypothesized that preschools would thereby become more effective referral agents.

The sixth component involved reporting assessment results to mental health center therapists who have responsibility for the child being assessed. Tracy (1977) found significant staff benefit from reporting procedures that stated client problems in behavioral terms, listed the client's personal strengths and resources, and identified explicitly negotiated treatment goals. A similar report was designed here. (See Appendix D).

The seventh component was the training component. It was implemented, by the writer, during the latter part of the practicum. Training addressed one of the identified probable causes of the problem. It was felt that training would be better received after therapists had sampled the benefits of assessment work done during the first months of the practicum. Training included didactic instruction and individual supervision in the administration of selected measures when requested. Training was offered to all staff and trainees who desired it and was evaluated by questionnaire by the recipients. (See Appendix E).

The final component of the solution was the dissemination of the results of the practicum work to the staff and the center administration. It was felt that such dissemination would help to remedy the perceived causal factor of the current antiassessment bias. The sharing of problem-

solving strategies was also central to the concept of the practicum effort.

In summary it can be seen that this solution strategy addressed both the perceived causes of the problem in the center and from the literature and was designed to meet the terminal objectives of decreased amounts of improper, misdirected, and too lengthy psychotherapeutic treatment of young children.

ORIGINAL
CALENDAR OF IMPLEMENTATION

Preliminaries

1. Permissions to implement.
2. Submission and approval of proposal.
3. Acquisition of assessment instruments.
4. Development of forms for the second and sixth components.

Month One:

1. Implementation of assessment components.
2. Implementation of daily practicum log.

Month Two:

1. Continuation of assessment components.
2. Continuation of daily practicum log.
3. Week four: Clinical peer review of random charts.
4. Adjustments if indicated by the review.

Month Three:

1. Continuation of assessment components.
2. Continuation of daily practicum log.
3. Implementation of training component.

Month Four:

1. Continuation of assessment components.
2. Continuation of daily practicum log.
3. Continuation of training component.

Month Five:

1. Continuation of assessment components.
2. Conclusion of daily practicum log.
3. Continuation of training component.
4. Peer review of all charts of serviced clients.
5. Dissemination of results to Center staff and administration.
6. Preparation of practicum report.

Report of Action Taken

The actions taken to implement this solution strategy were basically those which were outlined previously in this chapter. The timetable of implementation also follows to a great extent the original calendar of implementation. Significant changes in the Weber Mental Health Center during the implementation period dictated that some modifications occur. These obstacles to implementation were very instructive, however, and will be fully discussed later in this report.

In January of 1983 the Weber Mental Health Center's Youth Program Administrator granted approval to implement the solution strategy noted above. (See Appendix F). The administrator was enthusiastic about the idea of improving services as well as learning more about the often neglected early childhood aged client. Procedures were set up that would allow the young child and his or her family to be seen around the time they received their new client orientation and prior to being seen by their primary mental health therapist.

This system proved to be an effective procedure for the first two children that were evaluated. Parents were highly cooperative and wished to gain more information on their child and how they could help in the child's treatment. They found the orientation very useful in helping them understand their place in the treatment process and found that the evaluation gave them a greater understanding of the child.

It was during this first month of implementation that major changes occurred in the Youth Program at the center. Two of the staff members

left the already understaffed Youth Program. Due to budgetary restrictions the center was unable to fill those positions until the Spring of 1983. This resulted in a radical change in the admissions procedure for young clients.

There was no longer enough staff to conduct the new client orientation meetings and it was decided that new clients would be placed on a waiting list. The only exceptions to the waiting list would be cases that were deemed to be emergencies. As was previously noted in the analysis of the problem found in Chapter Two, young children's problems seldom result in violence to others or produce adult reactions of extreme urgency. This assertion held true during the period the waiting list was in effect. Two of the cases deemed emergencies involved young children.

A second facet of the waiting list time period directly influenced the implementation of the outlined solution strategy. The Program Administrator decided that children, for legal reasons, could not be evaluated while on the waiting list. In order to be evaluated parents first need to sign documents authorizing treatment. An evaluation is viewed as part of the treatment process. It was therefore seen as unadvisable to enter into treatment with a family, via the evaluation, and not provide further treatment for a period of several weeks. During this waiting list period evaluations were only allowed on those children who were accepted into treatment.

The waiting list period, the first in the center's history, resulted in a major shift in the population using services. As previously noted

the population served by the Youth Program consisted of approximately 30% in the early childhood age ranges of birth to eight years. This percentage remained fairly constant over time. The intake coordinator and the research and evaluation specialist noted a dramatic shift during this period. The birth to age eight population accounted for only 10% of the Youth Program clientele. This phenomenon was the result of parents of young children "dropping off" the waiting list while parents of older children remained on. Thus once again parents, as well as center staff were seen to be influenced by the young child's non-violent or "non-urgent" characteristics. The net result of this shift was to greatly reduce the number of young children participating in this study.

The discontinuance of the new client orientation resulted in modification of the implementation strategy. Many of the checklists that were normally completed during this meeting were completed at home by the parents after the evaluation and before the first appointment with the therapist or even after treatment began.

This approach was not viewed by the writer or staff as efficient or as the most effective. The original strategy resulted in a large amount of diagnostic data reaching the therapist before the new client did. The modified approach resulted in data reaching the therapist before, during, and after the commencement of treatment. This modification was deemed more useful in meeting the terminal objectives than a return to the status quo existing prior to the implementation of the

orientation.

The modification of the center program noted above represents the only major factor which substantially modified the solution strategy previously outlined. The only other modification was the delay of the training component which will be dealt with later.

The acquisition of instruments for use in a mental health setting proved to be instructive. Most major suppliers of instruments for psychodiagnosis cater to providers of services to the adult, adolescent, and older child client. Most of the instruments commercially available for young children are intelligence scales and developmental assessment scales.

Schoonover (1970) noted that intelligence scales seldom provided clinical data needed to make treatment decisions beyond the areas of cognitive functioning they were designed to measure. Developmental scales fall in a similar category. They provide useful global information but fall short in helping to target psychotherapeutic treatment strategies.

Most of the instruments that were found to be most helpful with this population were found in journals or in locally devised measures used by professionals specializing in treatment of the young child. The one notable exception to this was found in the Children's Apperception Test (CAT). This instrument has long been a mainstay in work with children and has great utility in its employment with young children.

A standardized format began to emerge for the assessment process. It was found to be useful with the young child and varies somewhat from the traditional assessment session used with the older child or adult. Its key characteristic is a rapid-fire pace of changing activities.

The parents were seen during the first few minutes of the evaluation. The examiner would observe how they would organize and present the problem. Dyadic interaction was also observed and rated. Parents were given a short structured interview in which they were asked questions regarding specific observed behavior, client strength and resources, and explicit treatment goals per Tracy's (1977) findings. These items were noted on the Early Childhood Assessment Report (Appendix D). Parents were then asked to complete several questionnaires and checklists while their child was being evaluated.

The child was then seen alone for a few minutes and several assessment measures were administered. In order to maintain the child's attention many of the items were interspersed with other measures. For instance, often one of Copel's (1969) informal projective questions would be asked between presentations of CAT-H cards. This was found to produce a more alert response on the measures than the traditional presentation given to older children and is consistent with construction and design of the intelligence scales used for young children.

Following the administration of indicated instruments with the young child, the parents were brought back into the examination room

and the young child would explain the "games" that had been played. The family would then be given a task to perform such as drawing a picture or building with blocks. Interactions would then be recorded and coded using interactional scales, usually the Allred Interaction Matrix. The family was then informed the evaluation was complete and it was explained to them how the information would be compiled, forwarded, and used in the treatment of the child.

The above description represents a typical evaluation. The measures used would vary according to the problem, the family, and the therapeutic situation. At times, observations would occur or additional evaluation appointments would be scheduled.

It should be noted that this evaluation format was designed solely for the purpose of determining if treatment was indicated and to help target that treatment. The evaluation differs from a standard psychological evaluation which attempts to compile data on every aspect of a client's functioning.

The implementation calendar called for an informal peer review of the charts to determine if any changes in the implementation strategy were needed. This was held in the final week of March, the second month of implementation. Only a limited number of cases had been evaluated at that point but all indications were that the solution strategy was addressing the perceived causal factors and meeting projections for the terminal objectives. No adjustments were deemed necessary.

The third month of implement saw the hiring of new staff and the demise of the waiting list. The phenomenon that surrounded the waiting list continued for several weeks. Many referring agencies, even at this writing, continue to tell their clients that a waiting list for services is still in place.

The change in the staff at this point made it advisable to delay the training component. It was felt that the new staff needed to learn their duties prior to receiving additional training. The training component was therefore delayed by one month.

The fourth month saw the beginning of the training component with the psychology interns who were training in the center. These were graduate students from Brigham Young University and the University of Utah who had received coursework in the general areas of evaluation and diagnosis prior to their internship.

All of the interns availed themselves of the didactic component of the training. Many also received supervision in the administration of the instruments previously mentioned.

The didactic component consisted of a survey of the current state of the art, a review of the literature in early childhood psychodiagnosis, and discussion surrounding the use of many of the instruments. Case studies and clinical examples were also discussed.

The fifth month saw the conclusion of the practicum. Training was given to the remainder of the Youth Program staff and the final peer review was held.

The training given to the professional staff was basically of the same nature. One significant difference was in the level of the presentation and in the requests for additional supervision. The staff was familiar with the field of assessment in general and many had been experienced in the use of one or more of the instruments listed. There were only two requests for supervision received from the staff. The option for supervision remains ongoing even after the completion of the practicum experience.

The clinical peer review was held at this time. The reviewer was a Ph.D. level psychologist at the center. This reviewer also served as practicum observer during the period of implementation.

Results of this practicum were shared in a large part during the training component. Copies of this report were also made available to center staff and administration as well as other interested professionals. Many of the components of the practicum remained in effect after the conclusion of its implementation.

Chapter Five: Results, Conclusions, and Recommendations

Peer Review Results

There was a total of ten young children evaluated during the course of this practicum. The clinical chart of each child evaluated was carefully reviewed in light of the criteria noted on the Peer Review Form (Appendix A).

Of the ten clients evaluated, ten were seen to be properly in treatment. Zero were seen as improperly in treatment. It was projected in the first terminal objective that less than 10% of the children would be improperly in treatment. This goal was met.

The second goal related to misdirected therapy. It was projected that less than 20% of the population served under this solution strategy would receive misdirected treatment. Of the ten children evaluated, only one was determined to be in treatment that was partially misdirected. Therefore, this goal was also met.

The third goal dealt with the reduction of therapy hours. This goal was not met due to an inadequacy in the practicum design. Due to the length of the practicum (22 weeks), only those clients who received their evaluation in the early part of the implementation were able to be monitored to the twentieth week. This resulted in such a small N that results and conclusions drawn from it would be misleading.

Training Evaluation Results

The Training Evaluation Form was administered to the four interns and six staff members who received training. Ten reported having had

previous training in the use of psychological tests. Four reported having had previous supervision in the administration of assessment measures.

Those receiving training were asked to evaluate the process by responding to questions about it along a four point scale. A response of one indicated strong disagreement while a response of four indicated strong agreement. In addition, training participants were asked in an open question format to identify strengths and weaknesses of the training.

The following were the mean scores for each of the five questions:

1. The instruction given helped me understand when to use tests. Mean = 3.5
2. The supervision given will enable me to administer these tests independently. Mean = 3.2
3. The instruction was given at a level I could understand. Mean = 3.8
4. Supervision in use of the tests was given in a positive manner. Mean = 3.6
5. I would take additional training if it were offered in a similar format. Mean = 3.7

Strengths of the program identified by participants clustered around the issues of outlining specific indications for specific assessment, handout and "hands-on" material, and the acquisition of practical information.

The weakness of the program most commonly identified was a need for additional supervision. This was found most consistently in the evalua-

tion forms completed by the psychology interns. This result was, therefore, not completely unanticipated.

Other Results

The clinical peer review and the training evaluation constitute the sources of objective data concerning the results of this practicum. In order to completely represent the results of the practicum, however, it becomes necessary to present the somewhat more subjective results of each of the individual components of the solution strategy.

The first component dealt with the acquisition and administration of the instruments listed in Appendix B. The lack of commercially available instruments and the resulting administration procedures are discussed fully in Chapter Four.

The second component dealt with the use of the structured projective interview suggested by Copel (1969) and found in Appendix C. It was found that Copel had worded several of his questions at a level that was somewhat advanced for the population served in this study. It was often necessary to delete the word "definitely" in questions IV and V. It was also found that the words "impossible" and "history" often required the presentation of synonyms to be understood.

The third component was the retention and use of the parent checklists in the new client orientation. Due to the limited number of staff during much of this practicum, the orientation was discontinued and the checklists found less frequent use in the program. A recent poll of the staff revealed that the need still exists for such a service.

The fourth component dealt with the assessment of family systems functioning. It was found that the fewer members of the client's family that were present at evaluation, the less accurate the child's clinical picture became. Although it became apparent that this component alone would not suffice as a solution strategy, it became equally as clear that omission of this component would radically alter the evaluation results.

Component five dealt with increased utilization of mental health and school collaboration. This component met with limited success. It became apparent in the area of consultation with preschools and other early childhood settings that there is a need for improvement in pre-service and in-service training of early childhood specialists in using mental health consultation. Mental health service providers are also in need of additional training in acting as consultants to early childhood programs.

The sixth component of the solution strategy was the use of Tracy's (1977) model in formatting the assessment report. The selected format is given in Appendix D. Therapist feedback indicated that this one page report form was very useful in planning treatment strategies.

The seventh component was the training program. This was dealt with previously and will not be reviewed here.

The final component of the solution strategy was the dissemination of practicum results to the Youth Program staff and administration. Much of the dissemination of information gathered as a result of this

practicum was shared with the staff and administration as part of the training component. Results of the terminal objectives were shared with the staff and administration of the Youth Program following the final peer review. This did provide a rationale for the program to continue further psychodiagnostic evaluations of young children.

Conclusions

A summary view of the results would indicate that this solution strategy was effective in reducing inappropriate and misdirected treatment of children eight years of age and younger. The results would also suggest that psychology interns and mental health staff were successfully trained in the area of early childhood psychodiagnostic assessment. The results of this practicum would not support the assertion that such a solution strategy is effective in reducing the length of treatment.

The results of implementing each separate component of the solution strategy would suggest that most useful instruments for early childhood assessment will be found in other than commercial sources. The results would also suggest a very positive effect in using Tracy's (1977) reporting model as well as using an even further modified form of Copel's (1969) projective interviewing. The implementation of this solution strategy also suggests a weakness in the area of training early childhood workers and mental health professionals in the area of mutual collaboration and consultation.

During the five months of implementation it became apparent that the most critical components of the strategy for reducing inappropriate and misdirected treatment were the use of appropriate instruments for parent and child, the assessment of family systems functioning, and the effective reporting of results. Any professional attempting to replicate the results achieved in this study would do well to concentrate on these areas. It is also possible that such a solution strategy could theoretically result in reduction of the length of treatment. Such data would have to be gathered over a longer time period than given in this study and would also have to take into consideration the mean and/or median length of patient treatment in the facility attempting such a study.

Sperber's (1970) assertion that assessment needs to be rapidly accomplished so that the client and the treatment can be quickly matched provided one of the main thrusts of this program. It provides the clinician with the causal link between the solution strategy and the results that were achieved.

It was found that while this pre-treatment evaluation was not as comprehensive as a full psychological evaluation that each had its place. The psychological evaluation was most appropriate when specific questions regarding a client could not be answered in any other economical manner. The pretreatment assessment was so treatment directed that it served best as a guidepost for the initial stages of treatment planning with the client.

Some of the most instructive information gained in this practicum was a result of the obstacles that were encountered during the implementation stage. In the analysis of the problem contained in Chapter Two several hypothesized causal factors were outlined. Among these were an administrative and staff bias against formal assessment, and a client characteristic that could best be described as a lack of political clout. Many of these causal factors appeared to be validated as a result of the problems encountered during implementation.

The factor of staff bias was altered as a result of the change of staff. Professionals were recruited from various graduate programs and were open to new experiences.

The problem of young child clients lacking system changing power was perceived by the writer as being a problem inherent within the service delivery system alone. The advent of the waiting period for treatment and the rapid "dropping off" effect of younger versus older child clients made it apparent that parents as well as professionals tend to share in the ignoring of early childhood symptomatology as insignificant. This, of course, is not borne out by the literature reviewed earlier in this report.

In summary, misdirected and inappropriate treatment in children's mental health programs can be reduced. A program which attends to child and family characteristics and reports them in a usable form stands the greatest possibility of achieving such results.

Recommendations

1. Those wishing to replicate this practicum would do well to utilize and expand the components dealing with early childhood assessment techniques, family assessment, and assessment reporting procedures.
2. Professionals investigating whether such a strategy would decrease length of treatment would be well advised to design their length of implementation in sufficient multiples of their mean or median treatment length to ensure enough data is generated to form the basis of a definitive conclusion.
3. Clinicians who supervise graduate students should give additional supervision to them in the area of early childhood assessment. Directors of graduate training programs should also include more coursework in assessment of the young child.
4. Practicing mental health professionals should work at the acquisition of skills that will enable them to act effectively as a consultant to early childhood programs.
5. Early childhood specialists should work toward the acquisition of skills that would enable them to use consultation from helping professionals in an effective manner.

APPENDIX A

EVALUATION OF APPROPRIATENESS
OF SERVICES

MEDICAL RECORDS - PEER REVIEW

CLIENT'S NAME: _____

SEX: M _____ F _____

AGE AT INTAKE: _____

DSM CODE AND DESCRIPTION

Axis I: _____

Axis II: _____

Axis III: _____

ASSESSMENT DATA IN THE CHART: _____

_____

_____

1. Does the diagnostic information contained in the chart support the need for psychological services? Yes _____ No _____

2A. In comparing diagnostic information at intake to the course of treatment, were the diagnostic impressions indicative and suggestive of the intervention employed by the therapist?
Yes _____ No _____

2B. If "yes" (to 2A) were the interventions helpful in treating the problem areas? Yes _____ No _____

3A. Using your best clinical judgement, did the treatment of this client appear to be too lengthy due to inadequate diagnosis?
Yes _____ No _____

3B. How many hours were spent in treatment? _____.

APPENDIX B

APPROVED EARLY CHILDHOOD PSYCHODIAGNOSTIC ASSESSMENT INSTRUMENTS

Behavioral

Adaptive Behavior Scales
California Psychological Inventory
Children's Problem Checklist
Fear Survey Schedule
F.O.R.T. Technique
Life Style Inventory
Piers-Harris Self-Concept Scale
Reinforcement Survey Schedule
Source of Stress Inventory

Developmental

Boyd Developmental Scales
Denver Developmental Screening Test
Vineland Social Maturity Scale

Family Measures/Parental Checklists

Allred Interaction Matrix
Becker Adjective Checklist
Checklist "C"-Taplin Version
Familial Pattern Analysis
Family Drawing Technique
FIRD Tests
Genogram
Marital Adjustment Test
MICS Areas of Change Questionnaire
Perceived Personality Traits Test

Intelligence Tests (when indicated)

Goodenough-Harris Drawing Test
Peabody Picture Vocabulary Test
Slosson Intelligence Test
Stanford-Binet Intelligence Scale
Wechsler Intelligence Scale for Children-Revised
Wechsler Preschool and Primary Scale of Intelligence

APPROVED INSTRUMENTS: Page 2

Projective Measures

Bender Motor Gestalt Test
Children's Apperception Test(s)
House-Tree-Person Test
Human Figure Drawing
Likes and Dislikes Questionnaire
Self Appraisal Inventory
Sentence Completion Tests

Psychoneurological

Auditory Verbal Learning Test
Bender Motor Gestalt Test
Body Schema Test
Clements and Peters Coordination Test
Controlled Word Association Test
Immediate Tactile Memory Test
Perseverative Behavior Test
Rey-Osterrieth Complex Figure Test
Rey's Tangled Lines Test
Spatial Disorientation Test
Tactile Discrimination Test
Tactile Function Test
Taylor's Lady in the Rain Test
Token Linguistic Test
Visual Interference Test

Psychosomatic Measures

Children's Psychosomatic Problem Checklist
Psychosomatic Status Checklist

Instruments for Adults

Beck Depression Inventory
Bender Motor Gestalt Test
Human Figure Drawings
Minnesota Multiphasic Personality Inventory
Mooney Problem Checklist(s)
Rotter Sentence Completion Test
Saxe Sentence Completion Test
SCL-90-R
Thematic Apperception Test

APPENDIX C

COPEL'S INFORMAL PROJECTIVES FOR YOUNG CHILDREN

I. If you had three wishes, what would they be?

A. _____

B. _____

C. _____

II. Tell me about three dreams you have had or would like to have.

A. _____

_____

B. _____

_____

C. _____

_____

III. Pretend a rich king just gave you 3 bags of gold. How would you spend each one of them?

A. _____

B. _____

C. _____

IV. Tell me three things that you know are definitely true.

A. _____

B. _____

C. _____

V. Tell me three things that you know are definitely impossible.

A. _____

B. _____

C. _____

COPEL'S PROJECTIVES: Page 2

VI. Who was the greatest person in the history of the world? Why?

_____

_____

_____

VII. Who was the worst person in the history of the world? Why?

_____

_____

_____

APPENDIX D

EARLY CHILDHOOD ASSESSMENT REPORT

Client Name _____ Age _____

Examiner _____

Date of Evaluation _____

Instruments Used: _____

_____

_____

Behavioral Description of Client's Presenting Problem: _____

_____

_____

_____

Examination Findings: _____

_____

_____

_____

_____

Client Strengths & Resources: _____

_____

_____

_____

_____

NEGOTIATED TREATMENT GOALS:

Goal 1: _____

_____

Goal 2: _____

_____

Goal 3: _____

_____

APPENDIX E

TRAINING EVALUATION FORM

Name (optional) _____

Answer the following with "yes" or "no":

I have had previous training in the use of psychological tests. _____

I have had previous supervision in administering tests. _____

Answer the following according to the scale below:

1 = strongly disagree

2 = disagree

3 = agree

4 = strongly agree

1. The instruction given helped me understand when to use tests. 1 2 3 4

2. The supervision given will enable me to administer these tests independently. 1 2 3 4

3. The instruction given was at a level I could understand. 1 2 3 4

4. Supervision in use of the tests was given in a positive manner. 1 2 3 4

5. I would take additional training if it was offered in a similar format. 1 2 3 4

The strengths of this training program were _____

_____

_____

This program could be improved by _____

_____

_____

APPENDIX F

To: Joseph E. Prantil, MSW/CSW
Youth Program Administrator

From: B. Mathews Hill, M.Ed.

Re: Pre-Service Assessment of Young Children

Date: February 2, 1983

As you are aware, I am currently completing graduate studies leading to a doctoral degree from Nova University. This is a practitioner oriented degree program with requirements for completing problem-solving activities. My specialization in this problem-solving activity has been the improvement of treatment of young children through improvement of their pre-service assessment.

I have documented this as a problem by means of a peer review of selected records and have arrived at a problem solving strategy through a thorough review of the literature and an assessment of current Center alternatives. The solution will consist of several parts which will be primarily performed by me in an attempt to solve the problem.

The solution strategy will require that all of the new intakes of children under eight be seen for a one hour evaluation a day or two after their orientation. Following this evaluation I will forward a brief, behaviorally oriented report to the child's case manager.

My solution strategy also calls for training others on the staff in the special methods of evaluating the very young. This will occur in the late spring or early summer.

As always, your help in improving therapeutic programming is deeply appreciated.

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